

4/14/10 POC accepted
B. Cavanaugh HFS III
PRINTED: 03/29/2010
FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN2355SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/16/2010
NAME OF PROVIDER OR SUPPLIER ORMSBY POST ACUTE REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3050 N ORMSBY CARSON CITY, NV 89703		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 3/9/10 and finalized on 3/16/10, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00024648 was substantiated with deficiencies cited. (See Tags Z 230 and Z 265) Complaint #NV00024660 was unsubstantiated with unrelated deficiencies cited. (See Tag Z 230) A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000	<div style="text-align: center;"> RECEIVED APR 08 2010 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA <u>DISCLAIMER CLAUSE</u> PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. </div>		
Z230 SS=D	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care	Z230			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

EXECUTIVE DIRECTOR TITLE DATE 4/7/10

STATE FORM

6899

VCOD11

If continuation sheet 1 of 4

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Z230	Continued From page 1 developed pursuant to NAC 449.74439. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to ensure laboratory tests (complete blood count and basic metabolic panel) were done as ordered for 1 of 4 residents (Resident #1) and failed to ensure that a Fentanyl patch for pain was promptly available following the physician order for 1 of 4 residents (Resident #2). Severity: 2 Scope: 1	Z230	Corrective Action Licensed Staff will be in-serviced on the requirement that physician's orders be followed. Implemented Measure to Ensure Compliance/Monitoring of Compliance Director of Nursing Services or her designee will conduct random audits of physician orders to ensure they are followed every month for three months and report findings to the facility Continuous Quality Improvement Committee.		4/16/10
Z265 SS=G	NAC 449.74477 Pressure Sores Based on the comprehensive assessment of a patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shall ensure that a patient: 1. Who is admitted to the facility without pressure sores does not develop pressure sores unless the development of pressure sores is unavoidable because of the medical condition of the patient; and This Regulation is not met as evidenced by: Based on record review, policy and procedure review, and interview the facility failed to ensure residents admitted to the facility without pressure sores did not develop pressure sores and failed to assess and monitor the development of a pressure sore in accordance with facility policy for 1 of 4 residents (Resident #2). Findings include: Record review revealed Resident #2 was admitted to the facility on 1/14/10, following a hospitalization. Her diagnoses included normal pressure hydrocephalous, abdominal pain,	Z265	Z265 Pressure Sores It is the policy of this facility that residents admitted to the facility do not develop pressure sores unless it is unavoidable due to the medical condition of the resident. Residents with Potential Risks Resident #2 developed a pressure sore while in the facility. Resident #2 has discharged from the facility. Residents residing in this facility have the potential to be harmed by the failure to comply with this policy. Corrective Action Licensed staff will be in-serviced on the following requirements: • The "Skin Integrity Evaluation Form" is to be used on admission to evaluate resident's skin and for three weeks following.		

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Z265	<p>Continued From page 2</p> <p>osteoporosis, and senile dementia.</p> <p>Review of Resident #2's record revealed a stage II pressure sore was identified on the resident's coccyx measuring 2 cm x 2 cm with 0 cm depth on 2/1/10. An order for treatment was obtained and DuoDerm was applied. On 2/5/10, an order was written for an air mattress. On 2/10/10, the wound had increased in size to 3 cm x 2 cm with a depth of 0.5 cm. New orders for treatment and included a referral to the wound clinic.</p> <p>Review of Resident #2's record revealed an admission skin assessment was completed on 1/14/10; a rash to the groin area was documented. Further review of the record failed to reveal weekly skin assessments were done. The Skin Integrity Evaluation form was not found. Review of the medication administration records (MAR) revealed that the area for the weekly skin assessments to be documented was blank for the months of January and February 2010. Review of the resident's care plans revealed that a care plan entitled, "alteration in skin integrity secondary to" was blank and had not been initiated.</p> <p>The facility's policy and procedure for skin integrity was reviewed. Review of the procedure revealed the resident's skin integrity is to be evaluated on admission and weekly for the three weeks following admission. Section II of the form is to be completed "no later than after the evaluation for Week 3 is completed." Nursing is then to establish a care plan using the skin integrity impairment care plan as a guide. The nurse is to complete a weekly visual skin inspection and any "skin ulcers/pressure ulcers/bruises/skin tears/incisions/wounds are to be documented on the Wound/skin evaluation</p>	Z265	<ul style="list-style-type: none"> • Documentation of weekly skin checks. • Any alteration to intact skin will be documented on the "Wound/Skin Evaluation and Documentation Form" and weekly thereafter until resolved. • "Alteration in Skin Integrity Care Plan" will be utilized for any alteration in skin integrity until resolved. <p>Implemented Measure to Ensure Compliance/Monitoring of Compliance Director of Nursing Services or her designee will conduct random audits of new admissions "Skin Integrity Evaluation Form", to ensure they are completed per policy; will conduct random audits of weekly skin documentation and follow-up to the "Wound /Skin Evaluation and Documentation Form" and Alteration in Skin Integrity Care Plan" for any alteration in skin integrity every month for three months. Findings will be reported to the facility Continuous Quality Improvement Committee.</p>	4/16/10	

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Z265	Continued From page 3 and documentation form when identified and weekly thereafter until resolved." Severity: 3 Scope: 1	Z265			

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If continuation sheet 4 of 4

TRANSMISSION VERIFICATION REPORT

TIME : 04/08/2010 07:38
NAME : ORMSBY POST ACUTE R
FAX : 7758414650
TEL : 7758414646
SER.# : BROF9J946601

DATE, TIME	04/08 07:32
FAX NO./NAME	13608168187
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